



ALERT

News from the UFMCC
on AIDS Legislation, Education, Research and Treatment.

JUNE & JULY, 1991

Editor: Rev. Dr. A. Stephen Pieters

**A Call To Prayer:
General Conference AIDS
Vigil of Prayer**

(By Rev. Houston Burnside, Jr.)

In this time of turmoil, it is all too easy to bury the issue of AIDS beneath a veneer of concern for other seemingly more pressing issues of our day. I remember my own comments to Rev. Steve Pieters as we conferred recently at the annual gathering of the Commission on Faith, Fellowship & Order in Palm Springs. Rev. Pieters had given some forceful and impassioned comments regarding the need to retain a focus on AIDS as a valid theological concern. I responded that while I agree that it was important to maintain our concern for those living with AIDS, it was just as important not to lose sight of the plight of others in our midst who are suffering under the oppression of neglect, illness, homelessness, hunger, poverty, sexism, racism, ageism, "ability-ism" and other "isms" that are present in our world.

Valid though these other concerns may be, I nevertheless used them to avoid dealing with my own issues regarding AIDS in our midst. I did not intend to minimize AIDS, though I did. I did not intend to reduce AIDS to just another issue amongst many, though I did. I did not intend to bury my feelings of helplessness and impotence when it comes to realistically dealing with AIDS in our midst, though I did. What I did is no more or less than most of us do when confronted with something that is uncomfortable, painful, and distasteful. What I did was to relegate AIDS to the realm of the insignificant and non-consequential.

"I Have Opened A Door" is the theme selected for our General Conference XV which is to be held in Phoenix in July. This very appropriate title reflects a growing feeling amongst many that the 1990's will be a decade of movement and growth for our fellowship and community. Part of this growth will be in the area of the affect and place of AIDS in our daily lives.

Someone once said that when one person has AIDS, we all have AIDS. When I first heard this saying, I was put off because ("after all") I didn't have AIDS. Soon after, during a memorial service for a friend who died from complications resulting from the disease of AIDS, in the midst of tears and pain, I began to understand that it wasn't just Gary that had AIDS: it was also his friends and family...those who loved and cared for him...that were grievously affected by his disease--we all had AIDS!

During our conclave in Phoenix, we have an opportunity to meaningfully deal with AIDS in our midst while maintaining our spiritual energy for the business at hand. The Board of Elders and General Council concurred with Rev. David Farrell and established a conference-long AIDS Vigil of Prayer. The Vigil will be held over the duration of General Conference XV, complementing and enhancing our business and spiritual gathering. Running from opening service on Sunday, July 14th, through the closing service on Sunday, July 21st, the Vigil will be represented by a "vigil candle" in all worship services. During the course of the rest of the week's activities, the Vigil will continue as an underlying theme for our proceedings. The Vigil will be maintained by volunteers on a rotational basis, coming from both clergy and laity...delegate and non-delegate.

A Vigil Candle will be lit at the opening worship service on Sunday, July 14th. This candle will then be transported to and from a Vigil Chapel prepared to enhance the conference spiritual experience. At the opening of each worship service, the candle will be placed in a prominent position on the altar, retrieved and returned to the Vigil Chapel at the conclusion. (A continually lighted presence shall be maintained from Sunday to Sunday, extinguished at the concluding benediction of the last worship service).

Proposed activities in the Vigil Chapel during the bulk of the week range from meditative prayer to homily and musical presentations. Early morning activities will include a 3-4 AM Earlybird Meditation presented rotationally by members of various of the fellowship sub-groups (ie: EXCEL, FFO, People of Color, White People Healing Racism, Women's Commission, Samaritan College, COL, World Church Extension, Student Clergy, etc.), followed by a 6 AM Sunrise Meditation. During the mid-day break between business meetings, a Noontide Meditation will be presented again by members of the various fellowship sub-groups. From 6-7PM, a Processional Meditation will be observed in preparation for transferring the Vigil Candle into the evening worship service. Additionally, from 11 to midnight each evening, invited celebrants will lead a Candle-light Communion service, giving closure and perspective to the day's activities.

Volunteers are being sought to staff the scheduled time slots. Many will be specifically invited to perform certain functions, though many volunteers are needed to cover the entire Vigil. I encourage pastors, leaders,

(Continued next page)

laity and friends to become involved in this important effort. There are some 140+ hours that need to be covered. If everyone is willing to do their part, there will be no heavy burden placed on any person or group. Placement on the Vigil schedule may be made by contacting

Rev. Houston Burnside
P.O. Box 300356
Escondido, CA 92030-0356
(619) 740-5931

* Or see Houston at a special sign-up table at General Conference.

Special arrangements may be made for churches, groups and/or individuals who wish to sponsor a time segment, for special program presentations. Make your reservations early, as "prime times" will fill up quickly.

Please prayerfully consider what role God is calling you to, as we lift up our hearts and voices in prayer and supplication. God does answer prayer: With the faith of a mustard seed, God will work a wonderful blessing through our answer to this call!

Dr. James Tinney used a phrase that has become a benchmark of our fellowship...For such a time as this. This phrase means for us that ours is a special time. We believe that God has indeed raised up the faithful to be blessed as well as to be a blessing. Knowing that God did not "curse" anyone with disease, we are particularly blessed in the midst of AIDS. Blessed, not in the sense of morbidity. Rather, blessed in the fact that we have gained much wisdom and understanding of what death and dying are all about. We have suffered the pains of loved ones torn from our midst in the prime of life. We have grown in character, as we have bonded with our brothers and sisters who are afflicted, declaring that their pain is ours.

God will work through our lives and our prayers to touch people in the hour of their deepest need...at the moment of their greatest desire. We have been tempered by the fire of human tragedy, and have received a spirit of perseverance from God. Our ministry has seen many friends pass into the arms of eternity, only to be strengthened in faith and resolve to continue on the path that God has set before us.

Pray for love, hope and healing, as we join together in an ever more meaningful AIDS Vigil of Prayer. God bless you. Amen.

Putting Together An AIDS Prayer Vigil

(By Rev. Dr. Stephen Pieters)

What's The Theme?

The theme for the 1991-92 AIDS Vigil of Prayer is "Fear Not, For I Am With You." (Isaiah 41:10)

When Should We Schedule It?

Many churches choose World AIDS Day, December 1, for their Vigil. In 1991, December 1 falls on a Sunday. This is also the first Sunday of Advent, and some might feel the Vigil would be more appropriate at another time of the year. However, many will see that the beginning of Advent is an excellent time to focus prayer on HIV/AIDS. The point is to choose a date that will not interfere with the flow of your church's life, and will be a time when the church's whole focus can be dedicated to the Vigil.

Why Are We Doing It?

The AIDS Vigil of Prayer serves to offer up in continuous prayer, our concerns and our feelings about HIV/AIDS. The Vigil can serve to focus the broader community's attention on the issue of HIV/AIDS. It can bring the local church and the larger community of faith together through a common cause, building ecumenical/interfaith bridges. It can provide the opportunity for education on many different aspects of the HIV epidemic. It gives the opportunity for concentrated prayer for healing, for hope, and for an end to this era of HIV/AIDS.

The AIDS Vigil of Prayer offers the opportunity for the church to give to the community-at-large through financial support of on-going AIDS Ministries and Service Agencies. At the original AIDS Vigil of Prayer at MCC San Diego, offerings were taken up at every service for local AIDS agencies, and for the UFMCC AIDS Ministry.

Most importantly, the AIDS Prayer Vigil gives the people an opportunity to remember and mourn, to focus their concerns about HIV/AIDS, and pray without ceasing for a cure, a vaccine, effective treatments, as well as for healing and comfort. Prayer works, and is one of the most effective tools we have in the struggle against HIV/AIDS.

Where Can We Do It?

Many churches are equipped to stage the AIDS Prayer Vigil in their own church. However, in some places, where the church rents worship space from another worshipping congregation, or where the sanctuary is too small for the crowds hoped for, arrangements with another church may be made.

Some churches use their main sanctuary for the periodic corporate worship services, while using a smaller chapel or office space (with an altar set up) for the ongoing Vigil. Others keep the main sanctuary open for the entire Vigil. Security personnel may be needed in some churches, particularly in the early morning hours, to assure security for people who are praying.

How Long, O Lord? How Long?

The original AIDS Prayer Vigil, held at MCC San Diego, was 50 hours long, beginning Friday evening with corporate worship, and ending Sunday evening with a closing service.

(Continued next page)

Some churches have chosen a shorter format, such as twelve hours on a Saturday or Sunday, or 24 hours, from Saturday through Sunday. Criteria in determining the length of the Vigil might include the number of people available for the Vigil, as well as the availability of space.

How Public Do We Want To Be?

The AIDS Vigil of Prayer has historically presented MCC's with a terrific media opportunity for educating the public about HIV/AIDS as well as MCC's role in the crisis. However, some MCC's, for many different reasons (ranging from being a small group in a "hostile" environment, to desiring a more private, intimate experience of prayer) choose not to publicize their event.

Some churches have chosen one year to make the AIDS Vigil a major public event, and the next year to let it be a time for internal concerns, grieving, and healing. The important point is that the Vigil is about prayer, and no matter the scope of the AIDS Vigil, prayer is the central focus.

Making The Vigil An Ecumenical/Interfaith Event

The Vigil is an excellent opportunity for building Ecumenical/Interfaith bridges. At churches as diverse in size and environment as MCC Rochester and MCC San Diego, Interfaith involvement has been a key ingredient to the success of their Vigils. Other denominations and faiths respect UFMCC's experience with HIV/AIDS, and many are very responsive to invitations to participate in Interfaith Services which begin or end the Vigil.

Rev. Cathy Elliott, Pastor of MCC Rochester, has used her affiliation with GRAIN (Greater Rochester AIDS Interfaith Network) to produce several annual Interfaith AIDS services, that boast music from groups as diverse as the Gay Men's Chorus, the Disciples of Christ Voices of Peace Youth Choir, the Zen Buddhist Chanters, and a soloist from Iglesia Mahanaim. Representatives from a Jewish Temple, many mainline Christian denominations, and the Islamic Center have participated in the Opening Worship of the Vigils, which have always received a great deal of local media coverage.

Rev. David Farrell, Pastor of MCC San Diego, sent out letters of invitation to every church/religious organization in the county, along with a response card, to join in MCC's weekend-long vigil and educational activities. Those who could not or would not attend the MCC Vigil were invited and encouraged to pray about AIDS in their worship that weekend. MCC San Diego has always enjoyed very positive media coverage of their AIDS Vigils.

RESOURCES

MCC San Diego created an excellent packet of information on how to put on an AIDS Vigil of Prayer in 1986, following their historic first Vigil of Prayer in January, 1986. This packet includes step by step

instructions in making this a Community and Interfaith event, sample letters of invitation, press releases, and schedules. This resource packet is available now through UFMCC Church Services, 5300 Santa Monica Blvd., Suite 304 Los Angeles, CA 90029; (213) 464-5100. Cost: \$3.00.

Resources for creating liturgies are plentiful. A sampling includes:

To Celebrate and To Mourn: Liturgical Resources for Worshipping Communities Living With AIDS, by the Rev. Louis F. Kavar. Available from Chi Rho Press, P.O. Box 7864, Gaithersburg, MD 20898; (301) 670-1859. Cost is: \$3.95 plus postage and handling.

Resources for Healing and Prayer in the Age of AIDS. Available from AIDS Ministries Program of Connecticut, 1335 Asylum Ave., Hartford, CT 06105; (203) 233-4481. Cost is: \$4.00 each, plus \$1.00 postage.

Worship in a Troubling Time: An AIDS-Related Resource for the United Church of Christ. Available from AIDS Program, United Church Board for Homeland Ministries, 475 Riverside Drive, 10th Floor, New York, NY 10115; (212) 870-3425. Cost is: \$0.50 each.

13th U.S. National Lesbian and Gay Health Conference

The U.S. National Lesbian and Gay Health Foundation announces its thirteenth National Lesbian and Gay Health Conference, including the 9th National AIDS/HIV Forum, July 24-28, 1991 at the Hyatt Regency in New Orleans, Louisiana. The conference, "Foundations of Care: Building Skills, Addressing Needs," includes day-long intensive seminars (such as the Spirituality and Ritual Institute) on Wednesday, July 24, and a full day NIAID-sponsored medical update on HIV/AIDS.

The Spirituality and Ritual Institute will be key-noted by Rev. Elder Troy Perry, and will also feature Rev. Shelley Hamilton and Rev. Steve Pieters. The Conference has dozens of speakers scheduled, including Phill Wilson, Virginia Uribe, Tim McFeely, Reggie Williams, Urvashi Vaid, Eric Rofes, Hilda Hildago, and Dan Bross.

Registration ranges from \$110 early registration for students, to \$205 Regular On-Site registration. For more information and registration form, contact: The NLGHF Registration, Office of CME/GWUMC, 2300 "K" Street, NW, Washington, D.C. 20037.

IN MEMORIAM: Rev. Rick Weatherly

Rev. Rick Weatherly, staff clergy at MCC San Francisco, died at 1 pm on May 25, 1991. A memorial service was scheduled for June 2.

(Continued next page)

Rick began his service as clergy with UFMCC in 1979 as worship coordinator of MCC Tidewater in Norfolk, VA. He then served from 1979-82 as minister of evangelism with MCC San Francisco. From 1982-84, he served as pastor of New Life MCC in Oakland, CA. Rev. Weatherly also served as counselor at the Spiritual Life and Clergy Care Center and on the executive committee of the Northwest District Board of Home Missions.

Rick received a bachelor of arts degree from George Washington University in 1979 and a master of divinity degree from Pacific School of Religion in Berkeley, CA in 1982.

Rev. Weatherly became clergy on staff at MCC San Francisco after reactivating his clergy status. He was very active in recent months as a person with AIDS in the MCC-SF congregation, offering hope and wisdom through his preaching and staff participation. He helped pioneer a regular spiritual support group for people facing chronic illness.

In lieu of flowers, gifts may be sent to the MCC-SF AIDS Ministry, 150 Eureka St., San Francisco, CA 94114.

AIDS Candlelight Memorial and Mobilization Speech

(By Rev. Sherre Boothman)

The UFMCC was one of the Sponsoring Agencies of the Eighth Annual AIDS Candlelight Memorial and Mobilization, held in over 40 countries this year. This speech by Rev. Sherre Boothman, Pastor of MCC in the Valley, N Hollywood CA, was delivered at the Los Angeles observance on May 19, 1991.

"There is, my friends, a profound difference between spirituality and religion. Recognize religion for what it is: the institutionalization of spirituality.

Healthy spirituality uplifts, renews, sustains, heals; it promotes a healthy self-esteem, empowers us to action for the sake of love; for the sake of healing ourselves and others; and for the sake of justice, which is nothing more and nothing less than love expressed communally.

That which condemns, increases self-hatred and self-destructive tendencies; that which causes low self-esteem and the paralysis of guilt and shame, may be from a religion. It is not a healthy spirituality! It may be about the abuse we have suffered as children and adults at the hands of family, and our culture. It is not about God!

A simple example from Christianity: to be a Christian is to understand one's self in some way as a follower of Jesus the Christ. I personally believe Jesus was the full embodiment of the will and word of God for human life. Jesus taught love, healed and did justice by

embracing those society had rejected. Jesus never taught guilt and shame. Jesus embraced those society had shamed! And Jesus never made anyone sick! The next time you hear a Christian say, "AIDS is God's judgement", tell them they need to reread their Bible!

My friends, realize that religious institutions will act for their own survival; and an unethical institution will sacrifice others to survive. It just so happens that upholding widespread bigotry in this country can be very profitable. Do not confuse the use of bigotry to get money from scared, frightened people with the word and will of God; or with any form of healthy spirituality.

Recognize it for what it is: a sick perversion of a once life-giving spirituality into a death dealing institution, using its societal influence to teach fear, and guilt, and conformity, and loss of self: willing to kill the very essence of personhood to fill its own coffers and increase its own political power. Do not give authority to such perversion. Do not give authority to anything or anyone who says that you are any less than a beloved, unique, beautiful creation of a wondrous Creator.

One of the characteristics shared by long-term survivors of AIDS is a positive, life-affirming, self-affirming spirituality. I believe such a spirituality is necessary for all who desire personal happiness and fulfillment.

Whether you image our Creator as male, female, both, neither, as some form of energy, and/or as simply your higher power; if your imaging gives you a sense of being loved and treasured; of being a good and loveable person; who, while you may yet sometimes act out of wounded places, you know you are embraced by the Universal One. And if your imaging empowers you to action on behalf of your own healing and the healing of others, and to act for justice in your midst, passionately pursue your spirituality.

If your imaging makes you feel condemned, DUMP IT! It is not of our Creator! You are under the manipulative power of some religious institution; and it is a tragedy in your life. God weeps that even one of us would feel we are less than God's Beloved!

Mahatma Ghandi was one of the truly holy people of our century. He once said, "When I despair, I remember that there have always been despots and murderers and for a time they can seem very powerful, but the way of truth and love always wins. Think of it, always."

When we find the faith and love of God which inspires such wisdom, then we too will find ways to challenge injustice. We will find the courage to walk more fully in the ways of love and truth. We will stand where Jesus, and Ghandi, and Susan B. Anthony and Sojourner Truth, and Martin Luther King, and so many others have stood. We will stand up to the bigotry and lies of any institution, religious or otherwise.

(Continued next page)

We will proclaim and live again the wisdom of Ghandi when he said, "I need such courage. For in this cause, I too am willing to die. But there is no cause for which I am willing to kill. They may arrest me; they may beat me; they may break my bones; they may torture me. They may even kill me. Then they will have my dead corpse. Not my obedience!"

Find a spirituality of such health and wisdom and we will together change the world!

And my friends, remember; the way of truth and love always wins! Remember, always!"

YOU MISSED IT, HONEY!

*(By Rev. Elder Jeri Ann Harvey, Evangelist)
[reprinted with permission from
"Evangelistically Speaking", Vol 1, 2/91]*

I will never understand us. We bellyache for years that we have no AIDS ministry and then when we get one (and a darned good one I might add) we don't support it. Oh a few of us do...too few.

We had 26 registered for the AIDS conference in Florida, in January 1991. When all was said and done we had about 50 attending. Fifty people for a Fellowship our size. Well, we had a conference and a half. Our speakers were great, the bonding of the participants was awesome, the workshops were informative and good and we had laughter and we had tears but more than anything we had HOPE.

There is always alot of new information about AIDS, particularly around Women with AIDS but we had about 4 women at this conference. It is distressing to see so much denial in a body that is losing some of its most talented and gifted people every month. The People of Color Department had excellent speakers that opened alot of minds and created some REAL dialogue. I think we LISTENED for a change and didn't feel threatened...We felt enlightened and challenged to think. We felt like a body of Christ.

"Speaking of AIDS: Choosing The Words Carefully"

(By Rev. Larry J. Uhrig)

The month of June marks the tenth anniversary of the AIDS epidemic in America. Much has been said during these years about the experience of AIDS. Many of the words used to describe the emotions and the experience of AIDS have been words like "Crisis," "Tragedy," "Loss," "Pain" and "Suffering." As I reflect upon my experience of AIDS, as I contemplate this decade of dealing with death, other words come to my mind.

I honestly cannot use words like crisis and tragedy any more. I find myself facing the reality of disease and seeing in the faces of those who have died a quality of life that can only be described with words like "Fulfilled," "Loving," "Courageous," "Strong," "Peaceful," "Simple" and "Alive." Over and over, persons near to death have told me that they have never been so alive as they have through their sickness. Others of us who have been diagnosed as HIV positive have said that we felt more alive now than ever. In the midst of AIDS the quality of life has become greatly magnified. People have come to see what was important and what was not. In this revelation, we begin to strip away the trivia of life and lay claim to the real stuff of life, like love and forgiveness. I write these words having just shared in another memorial service. In the past two weeks three friends have died. Tony died full of light and love. A kind of radiance filled his parting and blessed his friends. Words of testimony from lover, friends and family spoke of love, courage and hope. I did not hear words of fear. Rick died in San Francisco. He was filled with courage and peace. Jim died with a sense of having known victory over all fear.

It is critical for us as caregivers and healers to be very sure that words of fear be forever banished from our vocabularies. The experience of AIDS has led us into realms of spiritual power and vitality of life that cannot be diminished by sickness or death. This is true when people open to the spiritual reality which is the essence of life.

I have recently been recovering from a long bout with Hepatitis A. During the weeks of lying in bed, the TV became my close companion and friend. A love-hate relationship develops with the TV as time and days get marked by the program schedule. Each afternoon at four I spent time with Oprah. At the end of the Oprah show something strange would happen. As the credits rolled you would see an American Airlines jet as the official airline of the Oprah Winfrey show. Each day I would watch the plane and wait for the moment it soared above the horizon line. Each time it did, I felt a sense of freedom and release. I wondered, "Why was I so captivated?" Then I recalled how I loved to fly and especially loved those moments when we would break through clouds and rain and gloom into the brilliant sun above. An American Airlines plane crossing the horizon line became a symbol of what I knew could happen for all of us who know sickness and suffering. No matter the conditions of life, we could break free to soar above it all. I had seen it time and time again in the faces and testimonies of those who died. I had even longed to go with them. In this awareness, words like "fear," and others words which sought to threaten, vanished in favor of the words of life.

(Continued next page)

I know now it is possible to soar above this plane of life to see yourself connect with the Alpha and the Omega, the beginning and the end. When you are sure of life's end, then the stuff along the way becomes less significant. Even stuff like AIDS and events like death.

"Sing them over again to me, wonderful words of life, Let me more of their beauty see, wonderful words of life. Sweetly echo the gospel call, offer pardon and peace to all, wonderful words of life." Sometimes an old hymn like this one will merge with the moment and my spirit will soar again. So, as we mark time and seek to describe this past decade, let us be careful of the words we use. Let us intend to impart courage and life, hope and love to all. Let us intend to banish all fear.

HEPATITIS B & HIV INFECTION

(by Gabriel Torres, M.D.)

[reprinted with permission from "Treatment Issues", Vol 5, #4; May 15, 1991]

Hepatitis B is a virus which can cause serious disease, leading to liver failure, cirrhosis and liver cancer. The usual symptoms of hepatitis B, include a flu-like illness, fatigue, a lightening of the stool, occasional yellowing of the skin or eyes, and a darkening of urine color (jaundice). However, many persons who carry the hepatitis B virus (HBV) show no symptoms. In such cases, infection is usually detected by a blood test of antibodies developed against the virus, similar to HIV-antibody testing. Since immunization is available with successful, safe and relatively effective vaccines, screening for HBV is urged.

TRANSMISSION

Approximately 300,000 new cases of hepatitis B are diagnosed per year. Ten thousand of those cases require hospitalization. Six to ten percent of infected persons become chronic carriers and may infect others despite showing no signs of illness themselves. These numbers are unconscionably large given that HBV can be fairly easily prevented. HBV can be transmitted through contact with blood, semen, and saliva. Following the safer sex guidelines to prevent HIV transmission will help in avoiding HBV transmission as well, but those guidelines are not enough. It is important to note that because hepatitis B virus is more contagious than HIV, oral sex and deep kissing are much higher risk activities for the transmission of HBV.

While, historically, homosexual men have had a higher prevalence of HBV infection than any other single group, the advent of safer sex practices among gay men has decreased the number of new cases among gay and bisexual men in this group. On the contrary, cases attributable to heterosexual activity have increased 77% between 1982 and 1988.

PROTECTION BY VACCINE

The best protection from Hepatitis B is by vaccination, which may be effective in 85-95% of cases. Two types of vaccines have been developed which have been shown to protect uninfected individuals. Heptavax-B is a vaccine derived from the plasma of HBV-infected persons. Recombivax is another vaccine, which is artificially produced from yeast through genetic engineering. One study shows that the plasma-derived vaccine may be superior in building antibodies against HBV in uninfected persons.

Though the vaccine is prepared from human blood, the method used to purify the product, kills all types of viruses found in blood, including HIV. No case of HIV infection from the vaccine has been reported.

The Hepatitis B vaccines are administered as injections. Usually three injections are given over a six-month period, followed by a yearly booster shot. The most common side effect of the vaccine is soreness in the arm, at the site of injection.

The Centers for Disease Control (CDC) is urging vaccination of the millions of people at risk for HBV infection. According to the CDC, these include infants, heterosexual men and women with multiple sex partners, health care workers, gay and bisexual men, intravenous drug users, and persons with occupations which put them in contact with blood and body fluids (i.e. firefighters or emergency personnel, and morticians).

HBV INFECTION IN HIV

Hepatitis B has been shown to be a more severe disease in HIV-positive persons than in HIV-negative persons. HIV-infected persons may have the virus for a longer period of time, including more prolonged liver function test abnormalities and clinical illness. Additionally, HIV-positive people may be more likely to become HBV-carriers. The duration of protection from the vaccine seems to also be shorter in HIV-seropositive people. In one study of hemophiliacs, all of the 67 HIV-negative, hemophiliac patients who were vaccinated, developed and maintained antibodies after 4 years. But five of 11 HIV-positive hemophiliac patients did not retain antibodies, when tested 4 years later.

Though the vaccine may be less effective in HIV seropositive persons, it is still advisable because such vaccination may result in protection from a severe and debilitating disease. It is unclear whether HIV-positive persons should receive extra boosters at yearly intervals to maintain the adequate antibody amounts for protection. However, levels of antibodies, should be checked routinely as part of regular health maintenance.

For antibody testing and immunization in New York contact Community Health Project at (212) 675-3559. The total cost of screening for Hepatitis B antibodies is \$21.00. The cost of the vaccine is free.

ANTIVIRAL OPTIONS:

AZT, ddI or ddC

(By Gabriel Torres, M.D.)

[reprinted with permission from "Treatment Issues", Vol 5, #2; Feb 25, 1991]

Since ddI and ddC (two drugs similar to AZT) have become available on expanded access programs, it is increasingly difficult for patients and physicians to choose which drug to take. This article summarizes the most recent data on ddC, since updates on ddI and AZT have appeared recently in "Treatment Issues", and discusses some of the issues patients and health care professionals need to consider when faced with choosing among these three drugs.

ddC: Current Knowledge

Dideoxycytidine (ddC) has proven to be a potent inhibitor of HIV both in the test tube and in humans. In Phase I/II studies, conducted by the AIDS Clinical Trials Group (ACTG) to determine dosage and efficacy, ddC was administered to over 300 patients with AIDS or ARC. The trials showed that ddC effectively reduced viral reproduction as measured by p24 antigen levels. ddC also proved temporarily to increase T4 cell counts during the first eight to twelve weeks of therapy with gradual declines back to original T4 levels. The most frequent toxicity of ddC has been peripheral neuropathy, or nerve damage, primarily in the feet, which seems to occur more frequently at higher doses of drug (greater than 0.03 mg/kg). Symptoms of neuropathy include a sensation of pins and needles, numbness, and pain in the lower legs and feet. Symptoms seem to worsen temporarily after the drug is stopped (a phenomenon referred to as "coasting effect"). In severe cases, neuropathy has taken as long as six months to resolve. At lower doses of ddC (greater than 0.01 mg/kg) the neuropathy symptoms are less frequent and more readily reversible. Early identification of the symptoms and discontinuation of drug is the best way to prevent the neuropathy from progressing. Other less common side effects of ddC include skin rashes, mouth ulcers, elevated liver enzymes, and low platelet counts. Rare side effects, which have occurred in isolated cases include hearing loss, kidney failure, and abdominal pain.

ddC Availability

Under an "expanded access" program initiated in late September 1990, ddC became available for persons with AIDS and advanced ARC, who are unable to stay on AZT. Patients allowed to enter the program cannot tolerate AZT, show signs of progressive disease while on AZT, or are taking drugs incompatible with AZT.

To be classified as an "AZT-failure" a patient must have one of the following conditions after taking at least 500 mg/day of AZT for more than six months: three opportunistic infections (OIs) or cancers within six

months of treatment; a decline in T4 cell counts by 50, compared to counts when AZT was initiated, or a T4 cell count of 50 or less on two occasions one month apart; involuntary weight loss of 2-2.5 lbs. per week for at least four weeks; a measurable increase of virus as reflected in p24 antigen levels; or neurological deterioration or disability requiring special care.

To be classified as "AZT-intolerant," a person must have had one of the following reactions to AZT: anemia (decrease in hemoglobin of 2 gm/month); a depletion of white blood cells (total neutrophil count under 750); nausea or vomiting; severe headaches; psychosis; severe agitation or declining muscle strength (i.e., inability to climb stairs) from muscle damage (myopathy) caused by AZT.

"AZT ineligible" patients include those who require drugs that are incompatible with AZT, for example ganciclovir therapy for cytomegalovirus (CMV). Also considered "AZT ineligible" are patients who have never taken AZT, but have low white blood cell counts or severe anemia.

Additionally, patients who are ineligible for, or intolerant to ddI qualify for the ddC expanded access program. Although these patients are not required to demonstrate ddI intolerance, many who have had side effects from ddI may be candidates for ddC. These patients include those who have developed pancreatitis, hepatitis, elevated uric acid levels or severe diarrhea from ddI.

Hoffman-La Roche reports that more than 1,100 patients have been enrolled in expanded access programs for ddC. Of that number, only four patients have developed pancreatitis or elevated pancreatic enzymes, referred to as the amylase level. Of those four patients two had a previous history of ddI-related pancreatitis.

If abdominal pain, nausea or vomiting develop for a patient on ddC therapy, the drug should be discontinued immediately and a medical evaluation for pancreatitis should be performed. If amylase levels are five times higher than normal, ddC should be discontinued even if the patient has no symptoms of pancreatitis. In two patients on ddC, according to Hoffman-La Roche, diabetes and elevated blood sugar levels were reported, possibly suggesting that ddC affects the pancreas.

For patients with less advanced disease, and T4 cell counts under 300 (or under 200 in asymptomatic patients) ddC is only available through clinical trials.

ddC or ddI

Most of the patients receiving ddC or ddI under expanded access programs are patients with advanced disease who have had more than one year of AZT therapy and who have most likely developed AZT resistance. Most of these patients have low T4 cell counts.

(Continued next page)

The choice between ddC and ddI requires a careful assessment of the potential toxicities of each drug according to individual patient characteristics. Both drugs are tolerated well, yet require frequent monitoring (physical and neurologic examinations and laboratory assessments) in order to avoid adverse effects. The long-term effects of both drugs are still relatively unknown. Muscle wasting similar to the kind associated with long-term AZT use, has also been reported in several patients using ddI or ddC.

Patients who are at risk for pancreatitis due to predisposed conditions are probably better off choosing ddC over ddI. Some of the predisposing conditions include previous history of alcohol abuse; pancreatitis in the past; elevated triglycerides, uric acid levels, or intravenous pentamidine. All of the above conditions may increase the risk of pancreatitis.

For those intolerant of or failing AZT and ineligible for expanded access, the Community Program for Clinical Research on AIDS (CPCRA), a federally-funded program conducting clinical trials at 18 community sites throughout the U.S., is sponsoring a trial comparing ddI versus ddC in patients with T4 cell counts less than 300. In New York, the trial is being conducted by the Harlem AIDS Treatment Group. In Newark, New Jersey, the Community Research Initiative will conduct the trial.

ddC and AZT

Ongoing clinical trials combining ddC and AZT are investigating whether this combination offers an advantage over therapy with a single drug. Some trials compare ddC to AZT, others compare combinations of ddC and AZT, and still others evaluate the usefulness of switching back and forth between ddC and AZT every week or month.

In San Francisco, at the Sixth International Conference on AIDS, preliminary results of a complex trial comparing many different regimens were reported. The arms of this trial consisted of: low dose AZT (150 or 300 mg) combined with ddC (0.005 mg/kg); high dose AZT (600 mg) combined with ddC (0.01 mg/kg); or very low dose AZT alone (150 mg/day). In June 1990, 43 of 55 patients enrolled in this trial, were still on therapy. Two patients had to discontinue therapy because of neuropathy. Three patients had neuropathy that resolved and four developed low blood counts. All patients showed an early rise in T4 cell counts, which peaked between four and 12 weeks, followed by a gradual fall to original counts.

In November 1990, Dr. Douglas Richman gave an update of this trial at a meeting in Washington. So far, patients in each arm of the trial showed weight gain and rises in T4 cell counts. The high doses of ddC and AZT seemed to be more effective in suppressing viral reproduction, as measured by p24 antigen levels than the low-dose combinations of ddC and AZT. The least effective regimen seemed to be AZT at 150 mg/day alone.

Combination AZT and ddC may have the dual benefits of preventing resistance and minimizing the toxicity of each drug. For example, if AZT and ddC are alternated every other week or month, the time off AZT will allow for bone marrow recovery and the time off ddC will allow for nerve tissue recovery. Additionally, none of the actual antiretroviral benefits of the drugs will be lost. One trial has shown that neuropathy was more common in patients with pre-existing neurologic abnormalities, patients on high-dose ddC, patients on weekly (as opposed to monthly) alternating and intermittent schedules.

In the test tube, HIV strains from patients on alternating ddC/AZT remain sensitive to AZT, whereas strains from patients on AZT alone are uniformly resistant to AZT. Intermittent schedules where patients are taken off both drugs for any length of time run the risk of resurgent HIV replication and disease progression while not taking drug.

Conclusion

Though neither alternating, intermittent or combination regimens of AZT and ddC are recommended for general usage, it is imperative that the final results of these clinical trials be made available as soon as possible, since approval of ddC is expected in the near future. Community physicians and their patients need to be educated on the most appropriate dosages, schedules and combinations in order to maximize the benefits and minimize the toxicities of AZT, ddC and ddI. A consensus conference to examine all existing data on ddC, including the data emerging from the expanded access protocol, must occur in the near future to formulate a recommendation on regimens to be used once ddC is approved.

["Treatment Issues" is GMHC's newsletter devoted to providing reliable information on experimental AIDS therapies. Describing an experimental therapy should not be construed as recommending it. All new treatments should be done under a physician's care. For information on how to subscribe to "Treatment Issues" please write to: GMHC, Department of Medical Information, 129 West 20th Street, New York, NY 10011.]

For information on how to subscribe to this monthly newsletter "ALERT", write to: ALERT, c/o UFMCC, 5300 Santa Monica Blvd., Suite 304, Los Angeles, CA 90029; or call (213) 464-5100.